

In the Matter of

Christopher Anderson
Claimant

V.

Marinette Marine Corp.
Employer

and

Crum & Forster Insurance
Carrier

Date Issued: (Ref. June 23, 2000)

OALJ No.: 1999-LHC-2568

OWCP No.: 10-37499

DECISION AND ORDER

This matter arises pursuant to a claim for medical benefits and temporary total disability [TTD] benefits filed under the Longshore and Harbor Workers' Compensation Act, herein "the Act", by Christopher D. Anderson. Employer has stipulated that Claimant established a prima facie claim for compensation. The issue presented for consideration is whether Employer has rebutted the presumption in Section 20 of the Act by establishing that the incident at issue was not a substantial cause of Claimant's physical condition and related medical expenses.

FACTUAL BACKGROUND

Claimant is a 37 year old former employee of the Marinette Marine Corporation. He held various positions, but for the last two of his four years with Employer, he was a machinist/shipbuilder. The dispute at issue concerns an accident on Employer's property on January 8, 1998, when Claimant slipped on ice while walking between buildings and landed on both knees and his left hand.

Claimant testified at the hearing that he was wearing oil resistant steel-toed boots on the day of the accident. He further testified that two co-workers, Dennis Clad and Mike Lecass, saw him fall. Tr. 32. Neither co-worker testified at the hearing.

Claimant recalled that after he slipped, he immediately noticed pain in his left shoulder and pain extending from his lower back to his neck. He went directly to the Employer's Human Resources Department to report the accident and fill out an accident report. (CX 9, tab J-1). Claimant testified that he asked to see a physician but was told by Bill Getschall, an employee in the Human Resources Department, to wait and see how he felt. (Tr. 34). Claimant agreed, went back to work, and did not seek any medical attention for his injury until July, 1998. Claimant stated that he worked up to that point because the pain he felt from the January accident was manageable, although he contends that he did complain about his pain to both Bill Getschall and Karen Maddox, an Human Resources generalist for Employer. (Tr. 35-36, 108).

In contrast with Claimant's testimony, Employer disputes that he gave any notice of actual problems from his January 8, 1998 accident. Maddox testified that she first became aware of Claimant complaints arising from his January accident on July 28, 1998. (Tr. 110). Additionally, both Maddox and Claimant's immediate supervisor, Rick Schmidt, testified that Claimant was not working under any medical restrictions from January 8, 1998, through July 28, 1998, and he did not request any work accommodations during this period. (Tr. 85, 111).

Medical History

The first mention in the medical record that Claimant experienced any back pain as a result of the January, 1998 accident was noted by Dr. Horak on July 27, 1998, subsequent to his treatment for a May 19, 1998, knee injury. (CX 8 tab H4). The notation consisted of the following: "He has complained of soreness and pain in his neck with complaints of parasthesias and dysthesias in the upper extremities from neck to particularly the right upper extremity...impression is that of questionable radicular pain from cervical versus peripheral impingement..." (Id.). Employer then completed another injury report after it received a request for treatment. (CX 9 tab J2). Based upon Claimant's complaints of back pain, Dr. Horak ordered an x-ray of the cervical spine which yielded normal findings. (CX 3 tab C6). Although Dr. Horak opined in his January, 1999, notes, subsequent to a

September 10, 1998 letter he received from Dr. Sommerville, that Claimant's complaint were related to the 1998 slip and fall, (CX 8 tab H5), there is nothing in the notations indicating that he was informed by Claimant or was otherwise aware of any prior complaints of neck and shoulder pain or of the existence of cervical x-rays performed in 1995. Based upon his findings, however, Dr. Horak referred Claimant to Dr. Somerville, a neurologist.

A letter written by Dr. Somerville to Dr. Horak on September 10, 1998, contains the first medical reference to the slip and fall accident which occurred in January, 1998. (EX-3 and CX 4 tab D1). In his letter, Dr. Somerville noted that Claimant was referred to him because he was experiencing pain in the left shoulder and the neck, as well as numbness in both hands. He additionally found that the MRI did not demonstrate any significant pathology. In the addendum to this letter, Dr. Somerville added the following:

“I have been able to review Chris's cervical scan. It shows annular disc bulging at C4-5 and C5-6, but no frank herniation. We will discuss these findings with him. I told him that it was all right for him to return to work at his usual duties. I am not sure that physical therapy will benefit him on an on going basis, given the fact most physiologic healing has occurred.....” (EX-3 and CX 4 tab D1).

Dr. Somerville ordered an EMG be performed on September 29, 1998, which revealed that the study was consistent with chronic neurogenic change in a C6 distribution on the left. (CX 4 tab D4). In his office notes, Dr. Somerville suggested cervical traction and that the lathe Claimant operated at work be raised by Employer. On November 10, 1998, Dr. Somerville prescribed physical therapy for Claimant because the traction had not been effective. (CX 4 tab D5). Notations pertaining to Claimant's disability recorded his slow progress and stated that he felt better after returning to physical therapy subsequent to missed appointments during deer season. (CX 4 tab D7). A physical therapy report dated December 2, 1998, notes Claimant's report of increased pain and that Claimant was not aware of any activity which would have aggravated it. (Id.) The report dated January 27, 1999, mentions the bilateral carpal tunnel syndrome in Claimant's past medical history, although there is no mention of any x-rays or other diagnostic testing. (Id.). On

December 17, 1998, Dr. Somerville wrote to Dr. Horak that Claimant had a mild, but painful C6 disc protrusion and informed him of his intention to refer Claimant to a neurosurgeon. (CX 4 tab D8).

In evaluating the etiology of Claimant's condition, Dr. Somerville denied that the delay in seeking medical care affected causation, noting that Claimant had explained to him that Employer had discouraged him from seeking medical care after the accident. (CX 4 tab D9). To the contrary, Dr. Somerville, in a letter addressed to the insurance carrier, concluded that the "approximate cause" of Claimant's complaints was the 1998 slip and fall accident; however, like Dr. Horak, Dr. Somerville did not mention Claimant's 1995 injury or the medical records for that period of time. Dr. Somerville again attributed Claimant's complaints to the 1998 slip and fall accident in his referral letter to Dr. Harrison. (CX4 tab D10). After Dr. Somerville's referral, Dr. Harrison wrote a letter dated February 11, 1999, in which he reported that Claimant attributed his symptoms to his January, 1998, fall on the ice. (CX 5 tab E1).

While Dr. Horak and others had noted Claimant's complaints of pain in the thoracic and cervical spine, Dr. Harrison's February 11, 1999, letter mentions lower back pain, although lower back pain was reportedly denied by Claimant on previous occasions. (Id.) Dr. Harrison also found clinical evidence of carpal tunnel syndrome, but acknowledged that the MRI did not appear to reveal carpal tunnel. He attributed Claimant's pain to a myofascial injury of the cervical spine. He also stated that he "encouraged Claimant to continue his work activities as tolerated." (Id.)

Claimant returned to Dr. Harrison complaining of increased back pain. He stated that his neck and shoulder pain remained the same. Based on his complaints, Dr. Harrison prescribed physical therapy for his lumbar spine. (CX 5 tab E2). An MRI of the lumbar spine area dated June 9, 1999, was interpreted as demonstrating mild spondylosis, but an otherwise a normal results. (CX 5 tab E3). Conservative treatment of his cervical complaints continued apparently without resolving his neck and shoulder pain, and Dr. Harrison ordered epidural steroid injections in the cervical spine at C5-6. When this course of treatment was prescribed, Claimant reported only transient relief. (CX 5 tab E5). *****It is at this point that Claimant's first work restrictions were imposed on July 7, 1999, when Dr. Harrison recommended that Claimant not weld, that his lathe be raised, and that Claimant be

restricted to lifting no more than fifteen pounds. These restrictions were in place for two months. (EX 7).

After steroid injections failed to provide Claimant much relief, Dr. Harrison ordered a cervical and lumbar myelogram. The results of these tests revealed a normal appearing lumbar spine, but a cervical spine disc profusion at C4-5. (CX 5 tab E5-6). Dr. Harrison then scheduled and performed an anterior C4-5 cervical fusion on October 22, 1999. (CX 5 tab E7).

Following surgery, Claimant continued on total disability until a follow-up appointment in November, when Dr. Harrison reported that Claimant was much improved after his surgery, but still suffered from modest neck pain and numbness in his hands. He restricted Claimant to sedentary duty. (CX 5 tab E8). In December 1999, Claimant returned to full duty with a twenty pound weight restriction. In his notes, Dr. Harrison reported that Claimant continued to complain of lower back pain, but the etiology could not be determined. (CX 5 tab E9). One month later, the weight restriction Dr. Harrison imposed was lowered to ten pounds, but Claimant was also restricted to wearing a hard hat to four hours per day. Because Employer was unable to accommodate these new restrictions, Claimant was sent home on January 13, 2000, and he has been out of work since then.

Employer offered to retrain the Claimant as a welder and weighed the hard hat and shield. The weight of both pieces of equipment totaled 2.28 pounds. (Tr. at 115). Claimant testified that he was under the impression that the equipment weighed approximately eight pounds. Ms. Maddox testified that if Claimant was currently able to wear a hard hat all day and had a 20 pound lifting restriction, Employer would be able to accommodate his disability. (Tr. at 116). She additionally stated that it was her understanding that the welding restrictions were in place due to the "hard hat issue." (Tr. at 126-127). This understanding is supported by Claimant's testimony that he did not think welding to be a good option due to the weight of the helmet. (Tr. at 58). Additionally, there is a notation in a phone record from February, 1999, stating Claimant wished to get a letter from the doctor restricting him from welding due to his concern over the weight of the helmet. (CX 4 tab D6). Claimant was placed on total disability by Dr. Harrison on August 24, 1999. (EX 7). It appears, however, that the restriction Dr. Harrison imposed limiting Claimant to four hours per day of welding was apparently based upon a perception that the helmet weighed eight pounds. There is no evidence in the record

that Dr. Harrison would have imposed the same restrictions if he had knowledge of the weight of alternative head gear which weighed much less.

Employer offered evidence in the form of written memoranda and testimony at the hearing pertaining to Claimant's physical activities during the time surrounding his complaints of neck and back pain. Claimant admitted to bow hunting between 4-5 times before and after surgery, during a period of time in which he was on total disability from work. (Tr. 131). In addition, Rick Schimdt testified that he had seen Claimant towing a trailer on September 18, 1999. (EX 4, Tr. 90). Employer additionally submitted evidence that Claimant came to the worksite to collect scrap metal on August 19, 1999, after he had called in sick allegedly as a result of a reaction to an epidural shot. (EX 9, Tr. 86-90). Schmidt testified that based on his observations of Claimant at work during 1998, prior to Claimant requesting medical treatment for his neck, he had no reason to believe Claimant was suffering from any disability.

The record shows that prior to Marinette Marine, Claimant was employed at Patz Sales, Inc. for approximately three years. While working at Patz, Claimant filed a Wisconsin Workers' Compensation Claim. The claim arose from an injury which occurred August 7, 1995, and resulted in what was described as "numbness and tingling in the ulnar aspect of the right hand; ulnar nerve entrapment or carpal tunnel syndrome." (EX-2). Temporary total disability was claimed for the dates 8/18/95 through 9/12/95. It was noted in a Practitioner's Report that Claimant had experienced similar complaints at a previous job. An EMG was performed and the findings were interpreted to be consistent with a possible C7-8 radiculopathy or pinched nerve. The x-rays of his thoracic spine and cervical area were normal, as well as the CT performed on his neck. (EX-2) In a letter dated October 28, 1996, Dr. Gremban stated his opinion that Claimant's complaints stemmed from a pre-existing condition, and while he thought the chances were slight, he could not rule out the possibility that his problems might have been exacerbated by his work. (EX-2)

The record also contains a letter written by Dr. Turba noting that Claimant reported having an earlier neck injury for which he never sought treatment. This is the sole reference in the record to that occurrence. (EX-2). There is also an independent medical review conducted by Dr. Patel from an exam he performed on April 3, 1996. By this time, Claimant was employed by Marinette. Dr. Patel noted

that Claimant continued to have numbness in his right hand and was experiencing more neck pain. Claimant reported to Dr. Patel that he was experiencing pain in between his shoulder blades that was disturbing his sleep. Dr. Patel concluded that Claimant most likely was suffering from cervical disk syndrome with radiculopathy, and there was no connection to his symptoms and employment at Patz Sales. He attributed the neck pain to pathology in his cervical spine affecting the cervical disks. (EX-2). This history is significant because Dr. Harrison did not mention any reference to Claimant's complaints of cervical pain prior to the 1998 accident.

The first examining physician to note this past medical history was Dr. Kihm, as physician selected by Carrier/Employer to perform an independent medical review. Claimant reported to Dr. Kihm that he had numbness in his hands at his prior job, but stated it went away after he was off work for a couple of weeks. He denied any other prior problems or injuries relating to his neck or back. Dr. Kihm also reviewed x-ray films, two of which dated back to 1995. One was of the cervical spine and the other was of the thoracolumbar spine. These led Dr. Kihm to opine that the 1998 injury was not the first time Claimant had experienced problems with his back. This is further supported by portions of the record previously mentioned herein. He concluded the disc bulges revealed in the September 10, 1998, cervical MRI were minimal. He additionally read the September 24, 1999, myelogram as indicating a slight disc bulge, but reported that the myelogram was of poor quality and difficult to read. Dr. Kihm stated that based on the x-rays and myelograms that he viewed and upon his examination of Claimant, there appeared to be no justification for his surgery. He also attributed Claimant's lower back pain to deconditioning rather than a work related injury. Dr. Kihm found no reason to restrict Claimant from physical activities or from work at the time he examined him on January 15, 2000. (EX 1).

DISCUSSION

In U.S. Industries/Federal Sheet Metal, Inc. et al. v. Director, OWCP, 455 U.S. 608, 615 (1982), the Supreme Court upheld the Board's prior holdings that a claimant must first establish a prima facie case for compensation before the Section 20(a) presumption will be invoked. Thus, Claimant has the initial burden of demonstrating that he sustained physical harm or pain and that an accident occurred

within the scope of employment or that the working conditions could have caused his injury. Kelaita v. Triple A Machine Shop, 13 BRBS 326 (1981). The Supreme Court's interpretation stated that the claim "must at least allege an injury arose in the course of employment as well as out of employment" and that "the mere existence of a physical impairment is plainly insufficient to shift the burden of proof to the employer." U.S. Industries/Federal Sheet Metal, 455 U.S. at 615.

Once the Section 20(a) presumption is successfully invoked, the burden shifts to the employer to present substantial evidence to rebut the presumption that the injury was caused by the claimant's employment. Swinton v. J. Frank Kelly, Inc., 554 F.2d 1075, 1082, 4 BRBS 466, 475 (D.C. Cir.), *cert. denied*, 429 U.S. 820 (1976). Employer, in the present case, concedes that Claimant successfully established a prima facie case and is entitled to the Section 20(a) presumption that his injury arose out of his employment. Thus, the question for consideration is whether Employer successfully rebutted the presumption in accordance with the statutory and regulatory provisions and existing case law. If Employer rebuts the presumption, all the evidence in the record is considered in determining the causation of Claimant's condition. Del Vecchio v. Bowers, 296 U.S. 280 (1935).

The Seventh Circuit recently elaborated on the nature of the burden Employer must meet in order to rebut the presumption. American Grain Trimmers, Inc. v. Director, OWCP, 181 F.3d 810 (7th Cir. 1999). The Court found Employer's burden to be one of production, not proof. The Court additionally agreed with the ALJ's interpretation of the substantial evidence requirement to refer to the burden of producing "specific and comprehensive evidence, not speculation," before the Section 20(a) presumption would be defeated." Id. at 818. Furthermore, under the LHWCA, substantial evidence refers to such relevant evidence as a reasonable mind might accept as adequate to support a conclusion. This does not mean that the burden of proof shifts to the employer. Instead, it refers to the quality evidence required in order to rebut the presumption. Id. For the reasons set forth below, I find not only that the employer has rebutted the presumption, but further, that the claimant has failed on the record considered as a whole, to establish that his current condition is attributable to the January 8, 1998, accident at work.

The evidence which Employer submitted is a detailed independent medical review conducted by Dr. Kihm. Additionally, Employer submitted past medical

records relating to Claimant's 1995 injury while working at Patz. Claimant presented a case for causation based upon the opinions of three examining physicians who stated their belief that his fall in 1998 was the source of his current complaints. Employer is correct, however, in noting that the record is devoid of evidence indicating that these physicians were aware of Claimant's past medical history of cervical complaints during his employment at Patz and prior to his January, 1998, accident. This is significant in light of the fact that each physician attempted to document his past medical history, yet omitted any mention of Claimant's past cervical symptoms. In fact, Employer presented evidence that he had experienced similar problems even prior to 1995, thus indicating the existence of a chronic condition. (EX 2).

Thus, a 1996 letter written by Dr. Gremban attributed Claimant's symptoms to a pre-existing condition. Another letter from Dr. Turba, dated August 29, 1995, recites Claimant indication that he had suffered from a prior neck injury for which he never sought medical attention. Not only do Drs. Horak, Somerville, and Harrison fail to mention this portion of his past medical history, Claimant failed to mention having any cervical or neck-related problems, work related or otherwise. (Tr. 29-30). His lack of candor in this regard conflicts with evidence including the Practitioner's Report and the letter from Dr. Turba which document Claimant's similar complaints prior to working at Patz, and adversely affects his credibility.

In 1996, Dr. Patel conducted an independent medical review relating to Claimant's disability claim while working at Patz. In this report, Claimant is said to have complained of neck pain and pain between his shoulder blades that was disturbing his sleep. (EX 2). While Claimant testified that he could not recall other neck injuries, I find this testimony unreliable in light of his diminished credibility and evidence of Claimant's prior reports of a neck injury. (Tr. at 51). The complaint of pain between his shoulder blades is also noteworthy because it is identical to later complaints of pain which he attributed to his 1998 fall. While his reports of the dissipation of the numbness in his right hand are consistent throughout the record, his complaints to Dr. Patel of neck pain and pain between his shoulder blades is not consistent with his testimony at the hearing or the history he apparently reported to his physicians after 1998. He had indicated that his symptoms relating to his 1995 injury at Patz had resolved themselves in a few weeks after the accident, when in fact, he reported pain to Dr. Patel as late as 1996. The fact that he was experiencing similar symptoms before his 1998 fall is relevant since the opinions

regarding the etiology of his present condition rendered by his physicians cannot be accorded full weight if they were based upon an incomplete understanding of Claimant's past medical history. Similarly, Claimant states that he had complained of lower back pain "from the get go." (TR at 55). Yet, there is no mention of lower back pain in the medical records prior to the notation made by Dr. Harrison in his February, 1999 letter, a year after the accident.

The record further shows that Claimant did not seek medical attention for injuries resulting from his fall in January, 1998 until July, 1998. Claimant stated that he complained of pain and asked Bill Getschall and Karen Maddox for medical care. (TR at 33-35) There is, however, no evidence other than Claimant's testimony that Employer was aware he was having problems. To the contrary, even if Claimant's testimony were deemed credible that Getshall, on the day of the accident, initially advised him to wait and see if his condition changed, there is no evidence that anyone subsequently sought to discourage Claimant from reporting or seeking treatment for any continued discomfort he may have allegedly experienced. If his symptoms failed to dissipate following the accident, I do not believe Getshall's comment on the day of accident would have deterred Claimant from seeking treatment for over six months. Nor did Claimant allege to anyone prior to July, 1998, that the January accident had lingering effects. In fact, there is a notation by Maddox on July 28, 1998, stating her concern because she was unaware Claimant was experiencing any symptoms, (EX 6), and Claimant's immediate supervisor testified he had no reason to believe that Claimant was suffering from any disability. (TR at 85).

Considering Claimant's delay in seeking medical attention, the inconsistencies in Claimant's testimony which diminish his credibility, the fact the Claimant's physicians' opinions were grounded upon incomplete or inaccurate information provided by Claimant, and the report rendered by Dr. Kihm, alone, and in combination, I find that the Employer has produced "substantial evidence" which not only rebuts the Section 20(a) presumption, but renders the record insufficient to support Claimant's burden of proof that his condition is attributable to the January 8, 1998, accident.

Claimant argues that even if Employer were correct in the assertion that he

suffered from a pre-existing condition, he would still prevail, because pre-existing conditions which are aggravated by a work related injury are compensable under the LHWCA. Claimant maintains that he would continue to have the benefit of the presumption. When aggravation of or contribution to a pre-existing condition is alleged, the presumption also applies, and in order to rebut it, employer must establish that the claimant's condition was not caused or aggravated by his employment. Rajotte v. General Dynamics Corp., 18 BRBS 85 (1986); LaPlante v. GeneralDynamics Corp./Elec. Boat Div., 15 BRBS 83 (1982); Seaman v. Jacksonville Shipyards, 14 BRBS 148.9 (1981). *See Hensley v. Washington Metro. Area Transit Auth.*, 655 F.2d264, 13 BRBS 182 (D.C. Cir. 1981), *cert.denied*, 456 U.S. 904 (1982), *rev'g* 11 BRBS468 (1979) (employer must establish that aggravation did not arise even in part from employment).

Claimant, however, never alleged that his 1998 fall aggravated a pre-existing condition, nor did he present any evidence to that effect. In fact, his physicians were seemingly unaware that he even suffered from a pre-existing condition. This distinguishes the situation in the present case from the facts in Hensley wherein the claimant specifically alleged that is symptoms were caused when his work related injury aggravated a pre-existing condition. Written closing argument is not the proper time to assert aggravation of a pre-existing condition when none of Claimant's medical experts addresses this issue, and particularly under circumstances in which the evidence fails to establish that they were aware of a pre-existing condition or evaluated it in the context of claimant's present condition.

Nor do the precedents Claimant relies upon support his arguments. The claimants in the cases he cited offered specific medical evidence of a pre-existing condition and medical opinions regarding how their conditions were aggravated by the work related injury at issue. This record is barren of such evidence. Claimant did not acknowledge that he had a pre-existing injury which could have been aggravated by the January 8, 1998, slip and fall accident, and, but even applying the Section 20 presumption to an aggravation theory, Dr. Kihm, as the only physician who acknowledged the pre-existing condition refutes the notion that Claimant's present condition is work related . Accordingly, after careful review of

the record evidence considered as a whole, I find that Claimant has failed to establish that his back injury and subsequent treatment were related to his accident at work on January 8, 1998.

ORDER

IT IS ORDERED that Claimant's request for temporary total disability payments and medical costs is hereby denied.

STUART A. LEVIN
Administrative Law Judge